NC DEPARTMENT OF HEALTH & HUMAN SERVICES
CAP-I/DD REVIEW TOOL

PROVIDER NAME:		**AUDIT DATE:**	
PROVIDER #:		**NAME:**	
CONTROL #:		**SERVICE TYPE:**	
MEDICAID #:		**PROCEDURE CODE:**	
DOB/AGE:		**SERVICE DATE:**	
RECORD #:	**WAIVER:**	**UNITS PAID:**	

RATING CODES:	**0 = No** **1 = Yes** **6 = No service note**	**7 = Unable to identify service provider** **8 = Repaid** **9 = NA**	**RATING**

AUTHORIZATIONS / CONTINUED NEED REVIEW / PLAN OF CARE	
1. Is an authorization in place covering this date of service? **FROM: _____ TO: _____**	
2. Is the provider enrolled with Medicaid to deliver this specific service? **FROM: _____ TO: _____**	
3. Is the date of service covered by a current PCP? **FROM: _____ TO: _____**	
SERVICE DOCUMENTATION	
4. Does the service note(s) relate to goals listed in the PCP?	
5. Does the documentation reflect interventions/treatment for the duration of service?	
6. Does the service note reflect assessment of progress toward goals?	
7. Is the documentation initialed and signed within the designated time frame by the person who delivered the service?	
8. Do the units documented match units paid or billed? If no, write number of units documented: _____	
QUALIFICATIONS/SUPERVISION/RECORD CHECKS	
9. Is there documentation that the staff is qualified to provide the service billed? **FROM: _____ TO: _____**	
10. a. Is an individualized supervision plan in place for paraprofessional and AP staff? _____ **b. Has the plan been implemented? _____** **FROM; _____ TO: _____**	
11. Did the provider agency conduct a criminal background check on the staff person(s) who provided this service, prior to this date of service? **FROM: _____ TO: _____**	
12. Did the provider agency complete a Health Care Personnel Registry check on the staff person who provided this service, prior to this date of service? **FROM: _____ TO: _____**	
COMMENTS:	

AUDITOR:	**LME:**